State of California Department of Consumer Affairs

BOARD OF BEHAVIORAL SCIENCES
1625 North Market Boulevard, Suite S-200
Sacramento, CA 95834
(916) 574-7830
www.bbs.ca.gov

Meeting Minutes
Marriage and Family Therapist Education/Curriculum Committee
December 8, 2006

Phillips Graduate Institute
5445 Balboa Avenue
Encino, CA 91316

Committee Members Present:	Staff Present:
Dr. Ian Russ, Chair	Paul Riches, Executive Officer
Donna DiGiorgio	Mona Maggio, Assistant Executive Officer
Karen Pines	Christy Berger, Legislation Analyst
	Justin Sotelo, Regulation Analyst

I. Introductions

The meeting was called to order at 9:05 a.m. Dr. Russ thanked Jose Luis Flores and Phillip's Graduate Institute for their hospitality in accommodating the Committee meeting. He stated that the Committee's goal is to increase the input from stakeholders as the MFT curriculum is reviewed. He explained that the MFT curriculum is mandated by the state, and the Committee is examining those mandates and will be rewriting them in some form. The more educational and agency representatives that are involved in this process, the better the results will be.

Ms. Pines and Ms. DiGiorgio of the Committee and the audience members introduced themselves.

II. Discussion of the Recovery Model and its Core Elements

Dr. Russ explained that the Committee discussed the recovery model at its last meeting, and those in attendance found that there was little agreement on what the recovery model actually is, even though its use is mandated by the Mental Health Services Act (MHSA). Mr. Riches was able to find an explanation of the recovery model from the U.S. Department of Health and Human Services, included in the packets. MHSA is saying this is another way of handling diagnosis and treatment of mental health, and it is a core part of the MHSA. The questions are what role would this have in the formal education and training of MFTs, is this something that should be mandated as part of the MFT curriculum, and if so, how? Dr. Russ asked individuals from agencies if and how the recovery model is being used.

Mr. Riches stated that there is a lot of discussion with the Board about MHSA, public practice and all of the dynamic changes because this is really a new idea. It is not the sole focus, and the medical model has been there for a long time, but licensees need to be prepared to work in any environment, including a public setting.

An audience member, a private CBO who contracts with Santa Barbara County, who oversees a community treatment program, stated that an important factor is allowing more flexibility for MFT interns in county mental health. A lot of learning comes from this type of internship, much more so than private practice experience. For example, working with people in their homes, in the hospital and doing on-call crisis work.

Another audience member works for an agency on contract with the Los Angeles Department of Mental Health (DMH). She has been working on the core competency committee of the MFT consortium, which has also been looking at the MFT curriculum. They have incorporated the recovery model throughout their recommendations. Through the county, there has been training on the recovery model for staff and others. It is a way of approaching consumers, working with them, and including them in their own treatment.

Dr. Russ asked people to also address how agencies are dealing with a medical DSM-IV model along with the recovery model.

Mr. Riches asked for clarification about the core competency committee's recommendation, if they determined whether the recovery model should be integrated throughout the curriculum as opposed to separating it out. The audience member stated yes, they felt it should be integrated.

Olivia Loewy of the American Association for Marital and Family Therapy, California Division (AAMFT-CA) stated that one of the big issues regarding the recovery model is how to bill. There is a state committee through the California Institute of Mental Health called the Black, White and Grey Committee working on what is billable and what is not billable under Medicare and Medi-Cal that is incorporated as part of MHSA, and what is in-between. They are working actively right now to try and sort that out, and what is going to happen with the transformation of treatment in relation to the MHSA.

An audience member representing an agency stated that in the past they have used the psychosocial model, which is similar to the recovery model but integrates the medical model within. His agency does not bill for therapy, but instead under rehabilitative services, which include an array of services including case management, medication support, etc. One of the most important parts to the recovery model are immersion programs, which are often staffed with consumers. It is a more holistic approach.

Ms. Pines asked whether there are any aspects of a holistic or social approach that cannot be billed. The audience member stated that this was the case previously, but since the MHSA there are more flexible options.

An audience member who is an educator stated her concern that it was difficult for the Board to find material on the recovery model. She expressed her desire to not have any mandates from the board for things such as the recovery model that are not recognized generally by the educational and clinical community. As an educator, unless there is an overwhelming reason to do it, would be against squeezing anything else into the 48-unit requirement.

Mr. Riches asked for clarification from the educator by asking how much of the recovery model is truly additional, and how much are principles that would instead be refocused or given a new vocabulary. Another question is what part of this is classroom learning, to get the fundamentals, and what should be learned during practice experience.

The educator responded that all of the concepts about strength-based resources, multidisciplinary services and the postmodern perspective have been in most MFT curriculums for some time. The actual pragmatics for clinics, such as billing doesn't need to be in a master's program. She expressed her concern that if we can't find journal articles about the recovery model, is it real enough to be placed in law. Academics don't put something in a curriculum or textbook until it is much more recognized. It is very labor intensive it is to rewrite curriculum to follow a model.

Mary Riemersma from the California Association of Marriage and Family Therapists (CAMFT) stated that the recovery model should be integrated throughout a program, and is important but would not necessarily require additional units of study. Those doing the teaching need to convey differences in work settings. For example with the recovery model clinicians work side-by-side with consumers. This is a new way of thinking because if you worked with consumers in a private practice that would be considered a dual relationship. Students need these different frameworks so they are prepared for any environment.

An audience member who is the head of a DMH-contracted agency, has been very involved in the MHSA stakeholder's process, and is very familiar with billing. She does not think that DMH is asking agencies to bill for recovery. They are asking us to incorporate, under the full-service partnership, treatment that fully supports the client so that they can recover. Recovery is a mind set, a philosophy where the consumer has the right to be actively involved in the recovery process.

A student who graduated from Pepperdine's MFT program last year stated she has not heard of the recovery model, but is familiar with the components, which were part of her curriculum.

An educator from CSU Fullerton stated there is a content versus process issue. The content is already picked up in the programs, but the holistic, systemic view is a fundamental part of the MFT profession. To say there is one recovery model may be problematic, and may lead to turf wars. It is more of a process issue, how we use that language. Curriculum doesn't need to be altered to incorporate the content.

Ms. Pines stated that she teaches practicum at Pepperdine University and was talking about the MHSA to students, what it is going to be like now that MHSA is out there. She found that most field training is in agencies, not private practice. Because of that, they have a better understanding of those settings; it is not new to them.

An educator stated that he likens this to the multi-cultural requirement. One model for multicultural teaching says you teach one course, and that satisfies the requirement. Another model is teaching a cluster of courses; another model is where you integrate multicultural notions into the curriculum, that is the best way. Recovery model issues are already integrated throughout, so a separate course is not required.

Dr. Russ reiterated that what he is hearing is concern that this may not be a distinct enough model, but is rather a broad concept that is mostly in the curriculum anyway.

The educator responded that it would be difficult to teach a course on a model for which there is not peer-reviewed literature published. Dr. Russ promised to have a search of the literature done for the next meeting.

Michael Lewin from the MFT program at CSU San Bernardino stated he is not as convinced that schools are already teaching the concepts of a recovery model. He believes that MFTs have gone from private practice to doing much more work in the community mental health arena. So, are we training our students to do a good job in public mental health, or are we still stuck in a private practice mentality in our coursework? He believes it is still more private practice focused. It would be nice to have a more organized way to prepare students for community mental health.

Claudia Shields, training director at Antioch University stated she has a different perspective. Her first reaction was that they do teach some theoretical concepts of the recovery model, but on second, deeper look, this is not happening on a practical level.

An audience member who is a social worker stated that the MHSA is more outcome-driven, it is not just about symptom reduction. The medical model is used because you are assessing the clients and giving psychiatric care, but the principles of consumer-directed treatment are integrated, which is new to all of the mental health professions. We are not used to consumers leading groups, being involved in program planning, etc.

An audience member stated that her agency hasn't started teaching the recovery model to staff, as the DMH hasn't determined which recovery model they will require. There is a lot of literature on different recovery models, actually too much literature to sort through. It will take some time before we know which model DMH wants us to use.

Ms. Riemersma stated that additional courses should not be required, but the language of the recovery model needs to be integrated into the law so that it can be addressed within the programs. Needs to be recognition drawn to this model.

Mr. Riches stated from a regulator's standpoint that many of the educational requirements are stated at a high level of generality. They don't reference any particular school of therapy, and they should stay that way. What is in there are the core principles in the broadest sense, the domains of knowledge. He is sympathetic to educators regarding anxiety about adding content. He clarified that we are looking at integrating this perspective, not picking one specific type of recovery model to teach.

Ms. Loewy stated that a previous meeting discussed the distinction between curriculum and competencies. There were a lot of efforts from different groups to determine whether existing competencies are covering what needs to be learned in order to work effectively in the public system. So if there is a gap in the competencies, that may be something to look at. In terms of designating what kind of curriculum needs to be taught, they previously discussed letting schools develop their own curriculum that will result in the students having those competencies.

Diane Gehart from CSU Northridge stated that there isn't anything in MFT literature that has the recovery model in it, and it is not mentioned in current textbooks. Students can get a description of the recovery model and identify how it has integrated different therapy models such as humanistic and others. So giving students the foundational tools is important. She is concerned about legislating this model because it is more of a

philosophy and is hard to legislate a spirit, a set of values, or what seems like an ethical principle.

III. Discussion Draft for Revising Curriculum Statutes

Dr. Russ stated that this is not a true draft, but a way of framing previous discussions. He asked Mr. Riches to present it.

Mr. Riches stated that the statute as written is a cumbersome patchwork that contains duplications and is not clear. This committee presents an opportunity to revisit the requirements to make them more manageable and to look at the individual mandates and align them into a coherent whole. This is an opportunity to have government catch up with the real world.

Dr. Russ stated that he has been studying board forms and is learning how the schools ensure that they are meeting the requirements. He expressed his appreciation that schools' personal characteristics are very exciting, as long as there is a basis for people to come out as qualified. He asked what needs to be in a curriculum that is going to prepare students the best, and what of that should be a mandate.

Ms. Riemersma thinks that it is good to have all educational requirements in statute. She stated that draft subparagraph (a)(6) regarding treatment of children refers to regulations, but there are no regulations. We have managed to go since 1986 like this, so maybe regulations are unnecessary. Regarding (b)(5)-(10) there need to be protections for people in the pipeline since these courses would become part of fully integrated program. A timeline should be added so that people who already began their program aren't disadvantaged.

Mr. Riches stated that when we have an actual proposal we will need to include a timeline to give programs time to implement programs. This is all a very future oriented discussion and will not move quickly. He agrees that we do not want to write curriculum in regulation.

An audience member expressed her approval of the draft, felt it does a good job of eliminating duplication. She asked what does "within the degree" mean? For example, child abuse is currently a separate course, but is now proposed to be within the degree. Can schools provide this as an extension or continuing education course? Is it deliberately written vaguely?

Mr. Riches stated that the course would need to be credit level. The mode of delivery is the educational institution's responsibility, it doesn't matter to us. One of the foundational questions for us is, from a consumer's standpoint, shouldn't a professional degree program required to get a license include all the classes needed to get your license? Also the draft proposes this change because some of these courses are now only required prelicensure, but shouldn't you know things such as child abuse reporting before you get your intern registration?

An audience member asked for clarification about whether the courses could be offered at the extension level if they appeared on the transcript.

Mr. Riches stated a narrow interpretation based on this draft would be no, they would have to be credit level, but we can discuss this further.

Dr. Russ asked why a school would prefer to offer these as non-credit level courses.

The audience member responded that this is how they currently do it, and are a little unclear about whether what they are doing is the right thing for students.

Dr. Russ asked what difference it would make to schools whether these are required as for-unit courses or allowed as extension courses.

An audience member stated that they have already gone from 48 units to 60 units just to meet the requirements, so adding units would be difficult.

Another audience member stated it was confusing, it seems like you are bringing more into the degree program. He would prefer to discuss the timing of these courses of whether it should be learned prior to internship or prior to licensure.

An audience member from Phillips stated that there are financial aid considerations with number of units. Going up to more units is not necessarily a negative thing, but federal financial aid barely covers everything as it is. This is more of an issue at private schools. We can offer extension courses at a much lower cost at a student rate while they are in their degree program.

Mr. Riches stated that it sounds like schools need flexibility of requiring the content without specifying units or hours. There are a couple of models that can be looked at.

An audience member stated if you require new content only as coursework, you are disqualifying individuals that are already licensed. If these are offered as extension courses, licensees can also take them.

Mr. Riches explained that we are talking about the curriculum, which is a separate discussion from licensed population.

Dr. Russ mentioned how difficult it is for people licensed out of state to get the courses they need to become licensed.

Mr. Riches stated that the MHSA is challenging everybody's practice models and everyone is at a different starting position.

The Committee adjourned for a break at approximately 10:30 a.m.

Dr. Russ stated his appreciation of the discussion and encouraged ongoing audience participation at future meetings, and asked people to invite others whose points of view may not have been heard so far.

An audience member felt that the statute contains antiquated language regarding cross-cultural mores; there should be more emphasis on cultural competence and working with underserved populations.

Dr. Russ offered his email address and encouraged the audience to notify him regarding suggested edits to the language.

Another audience member asked for clarification about what “integrated” means. The notion of integrated seems to mean that you take all of the classes as part of your degree, but it is not clear. These are concepts put into the law, but are not clearly defined.

Ms. Riemersma stated that the language goes back to when the language was redrafted back in 1986. Marriage and family therapy is to be integrated throughout every course, as opposed to being taught a generic counseling program and then having marriage and family therapy courses thrown in.

IV. Discussion of Patient Composition at Public Mental Health Agencies

Dr. Russ stated that the statistics from the DMH provide an interesting look at diagnoses in public mental health. If we are preparing people for licensure, we need to know what people are doing once they get licensed. We need to know what kind of diagnoses are being treated, and this provides a breakdown by different demographics. Underserved communities by definition are not represented in the statistics. Another limitation is that you have to have a diagnosis in order to get treated and this can skew statistics at times. If you look at the national census, which is not here, it shows that approximately 20% of adults and children have some kind of psychiatric diagnosis. Another factor is difficulty in diagnosing children especially, as their diagnosis may change over time.

Ms. DiGiorgio asked for an estimate about what percentage of the population is not being served.

Sherry Brill from the Center for Individual and Family Counseling stated that the uninsured are in great need of affordable mental health care. She has people who can’t afford $15 a week but are in dire straits needing therapy. There is very limited help for these people.

Mr. Riches asked whether students are being prepared for the population they are going to see.

An audience member asked whether these were the most recent statistics, as they are dated 1998. Mr. Riches stated that these were the most recent statistics provided on DMH’s web site. The audience member stated that demographics have changed recently so she is concerned about the age of the statistics. Her sense is that the programs could only prepare people so much, and feels that the experience counts for a lot. Teamwork needs to happen between the schools and placements.

Another audience member stated she had been supervising students, and feels that certain things could be emphasized in the curriculum to better prepare students, such as case management, resources and progress notes. A lot of students aren’t familiar with how to access resources or do case management.

Another audience member from an Asian counseling center in LA County stated that language is a big issue. Also the unserved and inappropriately served populations. In the Asian population, for every Asian they are seeing there are 7-8 others who do not come in for various issues, such as language, transportation, etc. We don’t know how many will

never go there because they don't believe in mental illness or feel stigmatized. There are some cultures that don't have a concept of mental illness.

Dr. Russ stated he would like schools to comment on how they are doing with providing cultural competency training.

An audience member stated she has seen progress in this area. Would like to see more progress in readiness to serve underserved populations. People need to know how to do more than just therapy, they need to know what the MHSA is, they need to know what CalWorks is.

A director of clinical services at Jewish Family Services of LA stated that MFT students are often unwilling to do certain administrative functions such as paperwork because they can't count these types of hours toward licensure. Feels that they are being prepared more for private practice, stemming from the traditional structure. It would be great to educate them about what they need to do to work across different agencies and cultures.

Ms. Pines stated that she found, while working as the director of a social work agency, that MFT students' desire to do this type of work is a very individual thing. If we are going to have community mental health, maybe it needs to be reflected in the law so that they don't have this opposition.

Dr. Russ expressed his desire to fix this problem as quickly as possible, to get it to the Board.

Another audience member who receives MHSA funding through the full service partnership states that MFT students don't want to work under the full service partnership because they can't earn their hours that way.

Dr. Russ asked people from agencies to email him describing what the fix is for this problem.

Ms. Brill stated that another problem is about half of the students who come looking to be employed do not have any experience with their own personal psychotherapy. She would hesitate to put a therapist into a room with a client when they don't have this experience.

Dr. Russ stated that we can accept hours of psychotherapy toward licensure, but it would be difficult to require it. This would need to be required by the schools, and agencies should let the schools know they are not interested unless people have these qualifications.

V. Discussion of Desired Skills in Public Mental Health Agencies

An audience member stated that we are looking at a paradigm change, the consumers of mental health have said "nothing about us without us." Their perspective is now being brought into the process. Almost half of his staff are consumers of mental health in other agencies, and they help to keep him in check. He also mentioned that cultural sensitivity is more important than cultural competence, for example, you can study one culture for years and still not be competent. We need to think a little bit differently.

Another audience member stated that we are sending people out to do therapy in practicum after only six months to one year in the program, and she is concerned whether people are ready at this point, and whether we are able to define “readiness.” We also assume that faculty is competent to teach cultural competence, so this is a very complex experiment that we are in the middle of. She doesn’t think anybody can be ready with 150 clinical practicum hours – this is a short experience and there is a time and intensity issue.

Dr. Russ stated he is not as concerned about practicum hours, but is more concerned about post-degree experience, whether people are getting enough.

Another audience member stated that his program is a heavily private practice oriented model, though his students do work in community mental health and his students tell him they have a big adjustment. Part of it is cross cultural, doing a better job at treatment planning, and operationally defining goals.

Another audience member expressed her opposition to adding to the 150 hours of practicum because most people get more than that anyway, they just can’t count them.

Another audience member stated that a large number of trainees are working in schools, and doesn’t see that reflected in the conversation. As a profession we need to do a lot more to prepare them. Another issue is that interns feel as if they are being used as “slave labor.” They don’t get appropriate supervision, and more time is spent on billing issues instead of clinical issues.

An educator from CSU Long Beach has a class on cross-cultural counseling and infuses issues of diversity into all courses. This year opened up a clinic where they provide live supervision. Cross-cultural competency has turned out to be a huge issue for students even though they thought we believed we were doing a good job preparing them. Students often don’t really know what to do with it practically, they are spending a lot of time in supervision working on these issues.

An audience member from Phillips runs an agency in South Central Los Angeles, and works with many MFT students. More than readiness, we need more students that are willing and have the right attitude about working with people of color. She believes we can’t get them ready for everything, but she can work with anybody who is willing.

Another audience member stated that some of this discussion is a professional identity piece. MFTs are more and more seen as front line providers in community mental health and there is a recognition that MFTs need to be leading the field in this area. A lot of times students don’t know what they can do with this license. It has always been illegal for trainees for work in private practice, so they have to work in an agency in order to become an MFT. It has always been a part of the training, so now we’re just being more open about it.

Another audience member stated that one area not addressed are skills in outreach and engagement. You’re not going to get the clients unless you know how to outreach to them by going to their churches, community functions, being part of the community. Also regarding interns as “slave labor,” a lot of the DMH contracted agencies do pay their interns a salary. In her non-profit agency, interns get paid a small amount for every client seen. In another private nonprofit she has worked for the interns had to pay the agency a bit, so there is a big split between different types of agencies.

Ms. Pines stated we've come a long way today, and she is glad to see an audience from diverse areas of the profession. She feels we have a good start on a comprehensive proposal. She expressed her appreciation for all of the ideas presented today.

Ms. DiGiorgio stated the times are changing quickly and more is being realized about the integration of different types of issues. It is good to see professions working together without a turf war, working for the consumer and that is great.

Dr. Russ stated that in the end, we're going to come up with a proposal, and if these discussions with agencies, government and school are able to grow in the community, this is the greatest thing this committee can offer. We are looking at minimum requirements for licensure, but the discussion here is bigger than that, it is also about how we are going to serve underserved communities. He explained that the next meeting of this committee will be in March, but we are not sure yet of the location.

VI. Suggestions for Future Agenda Items

No suggestions were offered.

The meeting adjourned at approximately 12:00 p.m.